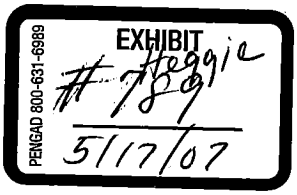
Exhibit 77



MICHAEL HEGGIE
MANAGER, REIMBURSEMENT
0R69; AP 34 Ext. 7-1784
INTEROFFICE MEMO

DATE: September 26, 1994

TO: J. Ward

RE: **Medicaid Rebate Program**

The following are issues which need attention. It is my strong feeling that by addressing these issues we can save money.

Dealing with Bulletin 12 (Tab1)

There are some HPD products that must be added to the Medicaid eligible list reported to HCFA.) (Tab 2) Several products have not been flagged for Medicaid reimbursement and we are probably out of compliance with the program.

Management of the HCFA List

This has never resided with Alternate Site, yet we are responsible for all of the cost of the rebates and for the jeopardy that we could put the corporation into should we fall out of compliance. Therefore, we must tighten up the control of the HCFA Medicaid eligible drug list. The responsibility must reside in Alternate Site. It appears to me that the responsibility for the list and/or the program has never been clearly defined.

Auditing of the Claims

States are required to submit claims to manufacturers for payment. When a manufacturer receives a claim which he views as not valid he has to challenge the claim. In the past we have done little auditing/challenging. In the few cases where we have challenged claims some of those challenges have not been resolved. While I am not sure of the reason for the non resolution of the disputes I believe it is due to lack of time and accountability. On many claims we are not sure that the information presented is correct.

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The data that each state presents in the claim can be flawed. Also states may claim more money than they are entitled to because of miss calculations on their part. There must be a person dedicated to looking at each claim from each state and ascertaining that the amount claimed makes sense. We cannot have unresolved disputes with states. These will come back to haunt us and give HCFA cause to look at Abbott.

Because of the exemptions for some of the settings in which drugs are given, i.e., hospice services, outpatient hospital services, and nursing facility services,(*Tab 3*); we can save money by challenging some claims for rebates based upon place of service. That requires time, follow up, etc. Also it is probably true that we are paying rebates that should not be paid by Alternate Site. I believe that some of the rebate dollars we are paying rightly should be charged to HBS. Proving that some of the rebateable products have been sold by HBS and found their way into the outpatient setting is probably difficult but could be checked. However, time and resources are involved again.

Pricing

I believe we could save some money by tightening up the procedure on the actual selling price of a drug versus the list price. PPD calculates the AMP(Average Manufacturers Price) for reporting purposes. If we list a drug at $500.00 but in reality sell it at $250.00, because of contracts, we are paying the rebate based partly upon the $500.00 list price. This could have us paying much higher rebates than is necessary. In the original program it looked like our exposure would be limited but as this program expands and our exposure grows pricing is an area for consideration.

Abbott NDC Numbers Sold by Others(Tab 4)

We have several products sold by us to McGaw. These products carry Abbott NDC numbers. Reporting for this rebate program is by NDC number. Therefore, we are paying McGaw's rebates and I believe we are not being recompensed by McGaw. Are there other products that fit into this same category?

Reserves

We currently are reserving $35,000 per month for this program. Considering the growth of the program we are under reserved.

Rebates Paid

- 1991 $76,661.58
- 1992 $392,538.55
- 1993 $443,008.44

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- 1994 $643,105.95 ($35K X 12mos=$420K) reserves are exhausted for 1994
- 1994 is through August At this rate we will be under reserved by 400 to 500K

Costs

Currently PPD is saying they will need $20,000 from HPD to add list numbers to the system as well as to refigure the Average Manufacturers Price for the drugs we will be adding. We need to address this issue so we can negotiate a better price or at least have PPD defend their figure of $20,000.00. This seems like a lot of money for systems work for a program that is already up and running.

Legal

We should try to determine the types of products to be included in the compliance with Bulletin 12. HCFA is saying any drug with an NDC number must be reported. Does that mean a tray with a drug filled syringe? We need to clarify this with HCFA. Legal should be involved. I contend that this has become a lucrative program for the states and states want to expand it where they can. HCFA is allowing the expansion of this program far beyond what was Congressionally intended. We need to ascertain what is legally rebatable and in what settings. PPD and other drug companies are not going to make a stand because Medicaid sales are sizable to them and making a stand might put their participation in the program in jeopardy. They do not wish to risk being thrown out of the Medicaid program costing themselves millions of dollars in lost sales.

Recommendations

- Add the products highlighted in yellow(enclosed) to the HCFA Medicaid list
- Work with Legal to determine which products fall under the law.
- Determine if we have past liability
- Reconcile any outstanding claims
- Put ourselves in full compliance
- Increase the reserves immediately and plan for the future reserves
- Dedicate a full time person to managing the program
- Give the oversight and accountability to me or someone in Alternate Site.

At the rate this program is growing we will be rebating ***1 million*** within a year or two. We need to check that growth. Some of the growth is legitimate but in some cases I believe we are paying more than we should. However this is decided we need to control this program more and better.

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